AGN. NO.

MOTION BY SUPERVISOR GLORIA MOLINA August 17, 2010

Back in December 2008, this Board approved the hiring of consultants to help the Board of Supervisors and Department of Health Services (DHS) reduce medical malpractice and improve patient safety. I am pleased and encouraged that today's report highlights the significant progress that DHS has made in this area and that overall, DHS has a developed and improving quality assurance system. For example, I am pleased to hear that the Department is largely compliant with the goal of completing a corrective action plan within 45 days, and that this has contributed to a reduction in medical malpractice claims. I know that many of these changes and improvements have not been easy, and they have taken a lot of work on the part of DHS leadership and staff.

Strong and effective corrective action plans have been a very high priority of mine for over 10 years. With every medical malpractice case I have reviewed, I have been adamant about the importance of substantive corrective action plans to ensure that the mistakes that we make in our health facilities never happen again. It is not about blame – it is about holding our people and policies accountable so that the same mistake never happens twice.

I also think that the consultants are correct that while significant progress has been made, there is still much work to do I do not wish to let the important recommendations of these consultants fall by the wayside. There are good recommendations in this report to help make our

MOTION

Ridley-Thomas _____

Yaroslavsky _____

Knabe _____

Antonovich _____

Molina _____

risk management and quality assurance system stronger, and I believe we must begin this work immediately.

I THEREFORE MOVE THAT the Chief Executive Office, in conjunction with the Department of Health Services Chief Medical Office and Quality Assurance team, develop an implementation plan to execute the most significant issues addressed in this report, including but not limited to:

1. Develop a system to ensure we are “closing the loop” with our corrective action plans (or CAPs) – a system that ensures that DHS or CEO are tracking the implementation and effectiveness of our CAPs across each of our facilities.
2. Develop a database to track patient safety trends among all of our health facilities, including a patient safety dashboard that is published and monitored.
3. A plan to reduce unnecessary bureaucracy to ensure that CAPs are being completed and implemented faster after an event.
4. A plan to ensure better coordination between patient safety staff at our clinic sites and DHS staff so that system-wide initiatives are understood and implemented equally at each of our facilities.
5. Adoption of Abaris’ recommendation that Quality Assurance staff report to DHS Director instead of Medical Director.
6. A plan to address staffing issues at Quality Assurance to address problems of expanding responsibilities, overwork and demoralization.
7. A policy that ensures that all future corrective action plans hold physicians and other medical staff responsible when they fail to follow established policies where patients are harmed as a result.

I THEREFORE FURTHER MOVE THAT the Chief Executive Officer report back to the Board of Supervisors with this implementation plan within the next 60 days.